WITNESS FORM

INCIDENT NAME	DATE AND TIME

WITNESS INFORMATION

FIRST NAME	LAST NAME	PHONE	PHONE (SECONDARY)

RELATIONSHIP TO PATIENT	UNUSUAL CIRCUMSTANCES OR ADDITIONAL INFORMATION

PATIENT INFORMATION

MEDICAL RECORD/TRIAGE #	LOCATION PATIENT FOUND	TIME PATIENT FOUND

FIRST NAME	MIDDLE NAME	LAST NAME	DOB	SEX

IDENTIFICATION VERIFIED BY
☐ DRIVERS LICENSE ☐ STATE ID ☐ PASSPORT ☐ BIRTH CERTIFICATE ☐ OTHER: _____

IDENTIFICATION # (E.G. LICENSE #) _____

☐ HAIR COLOR: _____ ☐ EYE COLOR: _____ ☐ APPROXIMATE WEIGHT/HEIGHT: _____

OTHER IDENTIFIERS (SKIN MARKINGS, PIERCINGS, CLOTHING, BELONGINGS, ETC.): _____
_

ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)

MORTUARY PREFERENCES

RELIGIOUS/CULTURAL DEATH PREFERENCES

EMERGENCY CONTACT (NEXT OF KIN):

FIRST/LAST NAME	RELATIONSHIP	PRIMARY AND SECONDARY PHONE

LOCATION (E.G. UNIT, DEPARTMENT)	NAME AND TITLE OF PERSON COMPLETING THIS FORM

COLLECT AS MUCH INFORMATION AS POSSIBLE.
STORE FORM WITH PATIENT MEDICAL RECORDS, STAPLE TO DECEDENT INFORMATION FORM IF APPROPRIATE.